respects, he was surprised to find that he could not see as well. On measurement he was found to require a convex lens 1 D. stronger for the right eye, and 0.75 D. stronger for the left. Within a month, however, the amount of urine and sugar having again increased, he was found to again require the former glasses.

Risley considers it probable that in these cases the change in the density of the tissue-fluids, suggested by the varying amount of sugar secreted with the urine, was sufficient to disturb the physiological relation of osmosis in the lens, and by this means cause the observed changes in the refraction of the eye.—*Trans. of the Amer. Ophthal. Soc.*, 1897, p. 121.

[Cases of diabetes giving the history of rapid changes in refraction have been encountered; but we do not know that any carefully observed case of such great and rapid change has been previously reported.—ED.]

Reid's Portable Ophthalmometer.—J. HINSHELWOOD (Glasgow) calls attention to the practical advantages of this instrument, which, although it was the subject, on the part of its inventor, Thomas Reid, of a communication to the Royal Society, five years ago, has not been so widely used as it deserves. In general arrangement it resembles other ophthalmometers. The doubling of the image is accomplished by a double prism, as in Javal's instrument. The object is an illuminated area of ground glass the size of which is controlled by an iris diaphragm. The curvature of the cornea is measured by the size of object necessary to bring the two reflected images of it in contact. When the cornea is spherical these images are circular. When it is astigmatic they are ellipses. The direction of the longer and shorter axes of the ellipses indicate the meridians of astigmatism.

The instrument is four inches long and weighs six ounces, occupying not much more space than an ordinary pocket ophthalmoscope. It can be used anywhere, with a patient standing, sitting, or lying down. A very moderate amount of light furnishes a satisfactory illumination. Both regular and irregular astigmatism are duly recognizable with it, and in the measurement of the former a high degree of precision (0.5 to 0.25 D.) can be readily attained.

The difficulties about using it are to hold the instrument steady and to focus it. The first is overcome by placing the little finger of the hand holding it against the patient's brow, and the second by gradually bringing the instrument toward the eye until the images are seen clearly.—*Ophthalmic Review*, November, 1897.

[The editor's trial of this instrument has satisfied him that it is an ophthalmometer of practical value and accuracy. Where a large instrument can be mounted to the best advantage with a proper illumination, the Javal ophthalmometer is probably a little better; but under other conditions Reid's portable instrument is more convenient and satisfactory.]

Ocular Crises in Tabes.—PEL (Amsterdam) reports recurring attacks of severe pain in both eyes accompanied by intense lachrymation, photophobia, and spasm of the orbicularis, lasting two or three hours, in a subject affected with tabes dorsalis. He denominates them ocular crises analogous to the gastric, intestinal, renal, and other crises known to occur in this disease.

But he claims that this is the first instance in which a tabetic crisis has been observed to involve a higher cerebral nerve—*i. e.*, the fifth. The crises thus far described have occurred only in organs rich in vagi and sympathetic fibres. If the varied endowments of the fifth nerve be considered, with its secretory, sensory, motor, and vasomotor fibres, it does not seem strange that this cerebral nerve should be affected with tabetic crises.—*Berliner klinische Wochenschrift*, 1898, No. 2.

DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

UNDER THE CHARGE OF

J. SOLIS-COHEN, M.D.,

OF PHILADELPHIA.

Foreign Bodies in the Nasal Passages.—DR. EDWARD F. PARKER exhibited to the South Carolina Medical Association (*Journal American Medical Association*, October 9, 1897) an accessory tooth which he extracted from the left nasal passage of an adult, twenty-nine years of age, who had consulted him for a chronic discharge from the nose. The tooth, evidently a canine, had been firmly embedded about midway between the anterior and posterior openings in the mucous membrane covering the bony floor formed by the hard palate. Its removal was followed by rapid amelioration of the symptoms complained of.

He also reported an instance of rhinolith removed from the left nasal passage of a lady, forty-five years of age, who for twenty years had suffered from a fetid discharge from the left side of the nose and chronic stricture of the lachrymal duct. A large, rough, irregular stone was found firmly lodged in an old suppurating ulcer just at the lower end of the tear-duct. As far as could be determined its exciting cause had been a piece of necrosed bone from a diseased tooth extracted years before. The annoying discharge ceased shortly after the removal of the foreign body.

Rare Fractures of the Nose.—DR. J. GARELL (*Annales des Maladies de L'Oreille, du Larynx, du Nez et du Pharynx*, October, 1897) reports a case of fracture of the inferior turbinated bone in a child, two years of age, due to a blow from a ball. There was no bleeding, and little attention was paid to it; but purulent and fetid secretion commenced in two weeks after the accident, and continued for two years, when the mother found a foreign body presenting at the orifice of the right side of the nose, which, when removed the next day, turned out to be the necrosed inferior turbinated bone.

Dr. Garel also summarizes a case reported by FREYTAG (*Monats. f. Ohren.*, March, 1896) which he states is the only other case on record. In the latter there was a fracture of the ascending superior maxilla; in addition the symptoms were far more acute, and there was deformity.